Disability Retirement Benefits Application Form

Use this form to apply for a Special Forces Pension Plan (SFPP) disability pension. Two types of disability pensions are available. A partial disability pension is paid when a member is unable to perform the regular duties of their work, but isn't expected that the disability will last their lifetime. A total disability pension is paid when a member suffers from a physical or mental impairment that can be reasonably expected to last for the rest of their lifetime and prevents them from being employed. The disability assessment will be based on a combination of medical evidence and rules applicable to the Plan.

To avoid delays, submit this completed form before you would like your disability pension to commence.
Please send this completed form and the *Confidential Medical Statement* (after completion by your physician(s)) to:
SFPP, 5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9 Fax: 780-421-1652

1. Member Information

member's first name _____ member's middle name _____ member's last name _____

member social insurance number

member's address _____ member's address effective date (YYYY/MM/DD) _____

city, town, village, etc. _____ province _____ postal code _____ country (if outside of Canada) _____

primary phone number _____ ext. _____ country code (if outside Canada/USA) _____
❑ Work ❑ Home ❑ Cell

You are only eligible for a disability pension if you commenced contributions to SFPP on or before June 30, 2007.

2. Definition of Pension Partner

Persons are pension partners on any date on which one of the following applies:

(a) they
  (i) are married to each other, and
  (ii) have not been living separate and apart from each other for a continuous period longer than three years;

(b) if clause (a) does not apply, they have been living with each other in a marriage-like relationship
  (i) for a continuous period of at least three years preceding the date, or
  (ii) of some permanence, if there is a child of the relationship by birth or adoption.

If you are not certain how the definition of pension partner applies to you, please contact the Member Services Centre at 1-877-809-SFPP (7377).

According to the definition above, I have a pension partner on the date that I am completing this form (please check one):

❑ **YES** If YES, please complete section 3. *Pension Partner Information*

❑ **NO** If NO, please skip to section 4. *Buyback Service in Pay*

SFPP

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3. Pension Partner Information

pension partner's first name

pension partner's middle name

pension partner's last name

pension partner's date of birth (YYYY/MM/DD)

marital status (married/common law)

Please check one:
❑ female ❑ male

4. Buyback Service in Pay

If you are currently paying for prior service, do you plan to complete your buyback payments?

❑ Yes, I will complete my payments.

❑ No, I will not complete my payments. Please prorate my service.

❑ N/A

If you are currently paying for buyback service, you must complete payment in full within 90 days of your termination date or you will only receive a partial credit of buyback service based on what you paid.

5. Pension Commencement Date

I want my pension to start on:

date (YYYY/MM/DD)

If the date you give is before you stop participating in the Plan, or before SFPP receives your application, your pension commencement date will be adjusted to the closest possible date allowed under the rules of the Plan. We will send you a *Retirement Benefit Statement* with your pension options. This statement will show the pension commencement date used to calculate those options.

6. Member Authorization

The information on this form is, to the best of my knowledge and belief, complete and accurate. I authorize my physician(s) to release to SFPP, its representative(s) and/or consulting physician(s), any information relating to the medical condition(s) which is the cause of my disability. This information is to be used to evaluate my application for a disability pension only and permission is **NOT** granted for any other use or disclosure.

member's signature

member's name (please print)

date signed (YYYY/MM/DD)

Please note:

- You are responsible for the cost of obtaining any information relating to your medical condition.
- **This is an official record that must be signed to be valid.** Mailing and fax information is at the top of page 1. Keep a copy of the completed form for your records.
- If you have questions, please contact the Member Services Centre, toll free, at 1-877-809-SFPP (7377).

If you are participating in SFPP, your employer must complete the following section. If you are no longer participating in SFPP, completion of this section by your former SFPP employer is not required.

7. Employer Use Only

a) Please explain whether the member is incapable of performing the duties of his or her position.

_____

_____

b) Is the member receiving Workers' Compensation Board benefits? ❑ YES ❑ NO

If yes, select one:

❑ temporary total disability ❑ temporary partial disability ❑ other

c) Is the member receiving long-term disability (LTD) benefits?

_____

d) If there was a leave of absence this year, record the *estimated* Pensionable Service and Pensionable Salary for the leave period.

Pensionable Service _____ Pensionable Salary _____

8. Employer Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

_____ _____ _____

employer name | employer number | member's termination date (YYYY/MM/DD)

_____ _____ _____

name of authorized person (please print) | phone number | ext.

_____ _____

signature of authorized person | date signed (YYYY/MM/DD)

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Confidential Medical Statement

The information on this form will assist SFPP in determining eligibility for disability pension benefits for the patient. No information, in whole or in part, will be released to any unauthorized person(s) without the patient's prior written consent. This statement will be held in strictest confidence and used solely to enable an assessment of the patient's disability by an independent medical consultant. The information on this form must be completed by a physician and returned to the patient. Charges for the completion of this report, if any, are the responsibility of the patient.

1. Patient Information

patient's first name | patient's last name | pension plan identification number

address

city, town, village, etc. | province/territory | postal code

2. Physician Information

physician's full name | area code | phone number

address

city, town, village, etc. | province/territory | postal code

3. Medical Relationship

a) How long have you been treating the patient?

b) When did you start treating the patient for the medical condition(s)?

c) When did you last examine the patient?

4. Medical Assessment

1. a) What medical condition(s) are preventing the patient from working?

b) What was the date of onset?

c) Please list all relevant symptoms

Personal information on this form is collected under the authority of section 39 of Schedule 3 of the Alberta *Joint Governance of Public Sector Pension Plans Act* and section 33 of the Alberta *Freedom of Information and Protection of Privacy Act* for pension administration purposes. If you have any questions regarding the collection of this information, contact the SFPP Member Services Centre at 1-877-809-SFPP (7377), or write to: 5103 Windermere Blvd. SW, Edmonton, AB T6W 0S9.

2. Detail your findings on examination. Please attach supporting documentation such as reports, x-rays, or other tests.

3. Please list any medication prescribed as a result of the medical condition(s) described in 1(a).

4. Please list any medical history relating to the medical condition(s) described in 1(a).

5. Describe any relevant medical problems other than the medical condition(s) described in 1(a).

6. Describe any activities that worsen the patient's medical condition(s) described in 1(a).

7. a) Do you consider the patient has become incapable of effectively performing the regular duties of employment as a result of the physical or mental impairment? ❑ yes ❑ no

   b) Do you consider the patient is suffering from a physical or mental impairment that can reasonably be expected to last for the remainder of the patient's lifetime and prevents the patient from engaging in any gainful occupation? ❑ yes ❑ no

8. The duration of the disability is:
   - ❑ Temporary (reasonable probability for recovery)
   - ❑ Permanent (low probability for recovery)

9. Please provide any additional information.

5. Physician Certification

I certify that the information on this form is, to the best of my knowledge and belief, complete and accurate.

physician's signature

date (YYYY/MM/DD)